General

Guideline Title

Health professionals working with First Nations, Inuit, and Métis consensus guideline.

Bibliographic Source(s)

Wilson D, de la Ronde S, BrascoupÃ© S, Apale AN, Barney L, Guthrie B, Harrold E, Horn O, Johnson R, Rattray D, Robinson N. Health professionals working with First Nations, Inuit, and MÃ©tis consensus guideline. J Obstet Gynaecol Can. 2013 Jun;35(6 eSuppl):S1-52. [129 references]

Guideline Status

This is the current release of the guideline.

Recommendations

Major Recommendations

The grades of recommendations (A-E and L) and quality of evidence (I, II-1, II-2, II-3, and III) are defined at the end of the "Major Recommendations" field.

Definitions

Recommendations

1. Health professionals should have an understanding of the terms by which First Nations, Inuit, and Métis identify themselves. (III-A)
2. Health professionals should have an understanding of the terms "cultural awareness," "cultural competence," "cultural safety," and "cultural humility." Health professionals should recognize that First Nations, Inuit, and Métis may have different perspectives about what culturally safe care is and should seek guidance on community-specific values. (III-A)

Demographics

Summary Statement

- Demographically, First Nations, Inuit, and Métis peoples are younger and more mobile than non-Aboriginal people. This requires extra effort on the part of health care professionals to establish an environment of trust and cultural safety in their workplaces as the opportunity to provide care may be brief. (III)

Recommendations

3. Health professionals should be aware of the limitations of statistics collected with respect to First Nations, Inuit, and Métis and should avoid making generalizations about mortality and morbidity risks when comparing First Nations, Inuit, and Métis with one another and with non-Aboriginal populations. (III-A)
4. Health professionals who wish to conduct research with First Nations, Inuit, and Métis must use recognized ethical frameworks that include the OCAP (ownership, control, access, and possession) principles, the Tri-Council Policy Statement, and community-specific guidelines. (II-2A)

Social Determinants of Health Among First Nations, Inuit, and Métis

Summary Statements

- Canada ranks 6th in the world on the World Health Organization Human Development Index; however, the First Nations rank 68th. (II-3)
- There have been centuries of formal agreements between European governments and First Nations. They were initially conducted in the spirit of friendship and cooperation, but later became centred on land ownership and resource extraction. Since they have been repeatedly dishonoured, there is an environment of mistrust in First Nations towards governments, their representatives, their policies, and anyone perceived to have authority. (III)
- The *Indian Act* and its subsequent amendments were designed to control every aspect of a Status Indian's life and to promote assimilation. It was also a tool that the government used to access First Nations' land and resources. (III)
- The intergenerational trauma experienced by First Nations, Inuit, and Métis is the product of colonialization. Residential schools, forced relocation, involuntary sterilization, forced adoption, religious conversion, and enfranchisement are a few examples of government policy towards First Nations, Inuit, and Métis that have created intergenerational posttraumatic stress and dysfunction. However, they continue to be a resilient people. (III)
- Most Canadians are unaware that a large proportion of Canada's gross domestic product is funded by monies garnished from natural resources extracted from Aboriginal lands, while First Nations and Inuit communities rely on insufficient money transfers from the Federal government. (III)
- Multinational companies extract resources from lands that are often on or adjacent to Aboriginal communities, or lands that are under land claims negotiations. The management of lands and resources by the provinces in some regions and by the territorial and federal governments in other regions has made it difficult for First Nations Inuit and Métis communities to communicate with multinational corporations, especially where land claim negotiations are ongoing or nonexistent. Multinational corporations do not provide revenues to these communities. Most Aboriginal communities are impoverished without adequate public health infrastructure, and without economic capital to improve their condition. (III)
- Jurisdictional issues today make it difficult to provide health care, take care of the land, and promote healthy communities. (III)
- Eating traditional country foods helps to preserve cultural identity, but increasing environmental contaminants such as lead, arsenic, mercury, and persistent organic pollutants may compromise food safety. (II-3)
- Given demographic shifts such as rapidly growing populations with large youth cohorts and the increasing urbanization of First Nations, Inuit, and Métis in Canada, it is an important reality that most clinicians will encounter First Nations, Inuit, and Métis in their practice. (II-3)
- Traditionally, men and women in First Nations, Inuit, and Métis cultures enjoyed equal and complimentary roles. Colonialization generally led to First Nations and Inuit women being objectified, disrespected, and ignored. Through specific pieces of legislation, First Nations women in particular lost their voices and powers within their communities, including their role in promoting traditional health and education. (III)
- The unemployment rate is much higher in Aboriginal communities than in those of non-Aboriginal Canadians. This is a major contributor to the gaps in socioeconomic status and access to equitable and quality health care. (II-3)
- The language of health outcome measurement often perpetuates negative stereotypes towards First Nations, Inuit, and Métis because outcomes are reported out of the context of the social, political, and economic circumstances. (III)

Recommendation

5. Health professionals should recognize the intergenerational impact of residential schools as one of the root causes of the health and social inequities among First Nations, Inuit, and Métis, with important implications for their experiences and practices surrounding pregnancy and parenting. (II-3A)
6. Health professionals should be aware that the discourse on health care policy and land claim negotiations often perpetuates negative stereotypes and often occurs without accurate reference to colonialization. (III-L)

Clinical Tips

Clinical Tips

- Intergenerational survivors of residential schools may struggle with poorer self-esteem. A low sense of self-worth may make a patient feel unworthy of the attention of her health professional.
- Recognize that many First Nations, Inuit, and Métis women, families, and communities have had significantly negative experiences with child protection and social services personnel, and that it can have a profound effect on their interaction with the health care system.
- Arctic char and caribou carry low levels of contaminants, and pregnant and lactating women are actively encouraged to consume these foods.

Health Systems, Policies, and Services for First Nations, Inuit, and Métis

Summary Statement

- Jurisdictional conflicts between federal, provincial, territorial, and band governments make it difficult to provide comprehensive public health and health services to First Nations. (III)

Recommendations

7. Health professionals should be aware of ongoing debates regarding jurisdictional responsibilities that impede access to good quality, timely, and culturally safe health care for First Nations and Inuit, and of Jordan's Principle. Jordan's Principle calls on the government agency of first contact to ensure that children get necessary and timely care by paying for services immediately and seeking reimbursement from the appropriate agency later. (III-A)
8. Health professionals who provide care to First Nations and Inuit should be aware of the Non-Insured Health Benefits program, its eligibility and coverage requirements, and the exceptions and special permissions needed in some cases. Health professionals should recognize that they have a vital role in advocating for their First Nations and Inuit patients and assisting with obtaining these benefits. Health professionals should be aware that Métis do not have access to Non-Insured Health Benefits and may face unique challenges accessing health care. (III-A)
9. All health professionals should acknowledge and respect the role that Aboriginal and Traditional midwives have in promoting the sexual and reproductive health of women and should be aware that this role is not limited to pregnancy and delivery, but often extends beyond the birth year. (II-2A)
10. Health professionals should inquire about their patients' use of traditional medicines and practices as part of routine health practices, including prenatal care. (III-A)
11. Health professionals should be aware that each First Nations, Inuit, and Métis community has its own traditions, values, and communication practices and should engage with the community in order to become familiar with these. (III-A)

Clinical Tips

- Go to the website for Non-Insured Health Benefits and familiarize yourself with the program.
- Familiarize yourself with the logistics of specialist care in your region or centre, including the surrounding Aboriginal communities serviced by your centre and what particular services are provided in each centre.
- Recognize that women have the right to make informed decisions in all aspects of their sexual and reproductive health care, including the right to use traditional knowledge exclusively or in combination with Western medicine.
- In your clinic communicate warmth, understanding, and culturally safe public health information that is relevant to First Nations, Inuit, and Métis

First Nations, Inuit, and Métis Women's Sexual and Reproductive Health

Summary Statement

- The harmony of First Nations, Inuit, and Métis societies was disrupted by European colonialization at the end of the 18th century, causing widespread effects on the sexual health of First Nations, Inuit, and Métis women and men. (III)

Recommendations

12. Health professionals should be aware of *Canadian Criminal Code* laws governing sexual activities in minors, including those under age 12, those between 12 and 16 years old, and those with a much older partner. (III-A)

13. Given the prevalence of sexual abuse and exploitation, health professionals must address the possibility of sexual abuse or exploitation once a trusting relationship has been established. All gynaecologic and obstetric examinations must be approached sensitively, allowing the patient to determine when she feels comfortable enough to proceed. (III-A)
14. Health professionals should be aware of the increased prevalence of human immunodeficiency virus/ acquired immune deficiency syndrome (HIV/AIDS) among First Nations, Inuit, and Métis and should offer HIV counselling and screening to women who are pregnant or of childbearing age. Culturally safe approaches to HIV and other hematogenously transferred disease counselling, testing, diagnosis, and treatment should be supported and adopted. (III-A)
15. Health professionals should be aware of the high rates of cervical cancer and poorer outcomes once diagnosed for First Nations and Inuit patients. Health professionals should strive to limit the disparity between their Aboriginal and non-Aboriginal patients by promoting culturally safe screening options. (I-A)
16. Health professionals must ensure that First Nations, Inuit, and Métis women have access to services for all their reproductive health needs, including terminations, without prejudice. Health professionals should strive to ensure confidentiality, particularly in small and fly-in communities. (III-A)
17. Health professionals should recognize pregnancy as a unique opportunity to engage with and affirm the sexual and reproductive health rights, values, and beliefs of First Nations, Inuit, and Métis women. (III-L)

Clinical Tips

- Truly understanding the personal context of your First Nations, Inuit, or Métis patients, and acquiring their trust takes time; however, it will allow you to provide them with optimal human papilloma virus (HPV) and cervical cancer preventive care that is responsive to their specific needs.
- If a woman is using metformin to regulate her blood sugars, make sure she is aware that ovulation may occur and she could become pregnant. A method of birth control suitable for the individual, taking into consideration her health issues, would need to be selected.
- Recognize that some women choose a termination largely out of fear that if carried to term, her child will be taken into care. With the intention of supporting a culturally safe experience that respects a woman's self-determination, health professionals should be careful to inquire about the context surrounding the choice to terminate, as well as the desire to observe a specific ceremony or protocol upon termination. For women who would choose to terminate out of fear that their child would be taken away, health professionals should work with social services and advocate for access to resources that support the woman's choice.

First Nations, Inuit, and Métis Maternal Health

Recommendation

18. Health care providers should ask about, respect, and advocate for institutional protocols and policies supporting the wishes of individuals and families regarding disposal or preservation of tissues involved in conception, pregnancy, miscarriages, terminations, hysterectomy, and other procedures. (III-A)
19. Health professionals should recognize that mental illnesses such as mood disorders, anxiety, and addictions are a major public health issue for many First Nations, Inuit, and Métis. (II-3B) Use of mood-altering substances that lead to addiction is often a mechanism for coping with the pain of their intergenerational trauma. Health professionals should familiarize themselves with culturally safe harm reduction strategies that can be used to support First Nations, Inuit, and Métis women and their families struggling with substance dependence. (II-2A)
20. Health professionals should support and promote the return of birth to rural and remote communities for women at low risk of complications. The necessary involvement of community in decision-making around the distribution and allocation of resources for maternity care should be acknowledged and facilitated. (III-A)

Clinical Tips

- It is important to many First Nations, Inuit, and Métis women to have family members present when seeing a health professional. The presence of family members at a birth is an important way many First Nations, Inuit, and Métis communities are "reclaiming birth" for their healing. Ensure that there is adequate space and chairs so that everyone can be seated at the same level, including the health professional.
- Instruct staff to inquire about best appointment times rather than assigning them. Be aware of a patient's travel context in terms of

Clinical Tips

distance, financial constraints, child care challenges, etc. If you are receiving patients from the North, be aware of flight schedules and travel time and schedule your appointments accordingly.

- Use your prenatal sheet: the checklist on your prenatal sheet can help you identify barriers and challenges to a healthy pregnancy and inquire about the patient's socioeconomic situation in a sensitive manner. Go through the sheet one question at a time, ask follow-up questions sensitively, and allow time for your patient to respond.
- Ask your patient about her support networks and if there are other agencies involved in her care, such as mental health or social services.
- For many First Nations communities, tobacco has a sacred role in healing and ceremonies. Being culturally safe includes respecting this sacred role and clearly distinguishing between smoking and ceremonial tobacco use.
- Communication and collaboration is important. Engage with others in your community of practice to ensure continuity of culturally safe care, including within intervention chains, should they be needed.
- Know your local social service resources, personnel, and their contact information, and establish a collaborative rapport with them. Encourage your local social services to connect with you on an ongoing basis so that you can strengthen efforts made to achieve positive outcomes.
- Be aware of and educate staff about patterns of automatic referral and understand that flags are flexible. When appropriate, work collaboratively with medical and social services to implement preventative care and support your patient and her family in improving outcomes.

Mature Women's Health

Recommendation

21. Health professionals should be aware that there is a great lack of research, resources, and programming about mature women's health issues, including menopause, that is specific to First Nations, Inuit, and Métis. Health professionals should advocate for further research in this area. (III-A)

Changing Outcomes Through Culturally Competent Care

Summary Statements

- Research has shown that where cultural competency strategies have been implemented, health outcomes and patient satisfaction have improved. (II-3)
- Subtle racism may occur without conscious intent, and is therefore best defined and identified by those who experience it. (III)

Recommendations

22. Health professionals should seek guidance about culturally specific communication practices and should tailor communications to the specific situations and histories of their patients. (III-A)
23. Health professionals may express to their patients that they wish to establish a respectful rapport through listening, acknowledging differences, and encouraging feedback. (III-L)
24. First Nations, Inuit, and Métis should receive care in their own language, where possible. Health care programs and institutions providing service to significant numbers of First Nations, Inuit, and Métis should have interpreters and First Nations, Inuit, and Métis health advocates on staff. (III-A)

Clinical Tips

- Understand that there can be large cultural variations between patients. Get to know your First Nations, Inuit, and Métis patients individually and do not make assumptions.
- Schedule longer appointment times. Investing more time from the beginning helps establish a more effective and respectful rapport. Health professionals should be aware that the health narrative begins with the context and ends with the individual. This is rooted in language as well as in the value of humility, and it requires professionals to be skilled in active listening. Health professionals should appreciate that adapting their practices will actually save time in the long run and that giving the patient more time is an investment in the care. Recognize that when patients are not listened to, it is a continuation of the oppression.
- Try to familiarize yourself a bit with the culture so you can get a sense of a woman's expectations and preferences about medical examinations and health practitioner–patient interactions.
- Verify your patient's understanding of your recommendations. Do not assume that they understand what you are asking them to do or

Clinical Tips

how to do it. For example, they may not know where to go to get a blood sample taken.

- Rather than viewing the individual and the culture as barriers to the delivery of care, it is better to consider how our beliefs and values as health care providers, and the system in which we practise, has created challenges for First Nations, Inuit, and Métis health and well-being.
- For many First Nations, Inuit, and Métis a positive experience from first entering the clinic or hospital is critical to feeling welcome and safe. Educate front-line staff, including front desk staff, on key principles of cultural safety. Greet all patients in a respectful, warm manner, even if they are late, and train staff to do the same: doing so will help ensure that the first interaction with a patient is a safe one. Be aware of policies or common practices that may be discriminatory, for example policies or routine practices of automatic drug screening upon presentation for labour and delivery.
- Being able to provide culturally safe care involves a learning process. It takes time to build and refine effective relationships with First Nations, Inuit, and Métis. Patience, compassion, curiosity, and genuine interest are needed.

Definitions:

Quality of Evidence Assessment*

I: Evidence obtained from at least one properly randomized controlled trial

II-1: Evidence from well-designed controlled trials without randomization

II-2: Evidence from well-designed cohort (prospective or retrospective) or case-control studies, preferably from more than one centre or research group

II-3: Evidence from comparisons between times or places with or without the intervention. Dramatic results in uncontrolled experiments (such as the results of treatment with penicillin in the 1940s) could also be included in this category

III: Opinions of respected authorities, based on clinical experience, descriptive studies, or reports of expert committees

* Adapted from the Evaluation of Evidence criteria described in the Canadian Task Force on Preventive Health Care.

Classification of Recommendations†

A. There is good evidence to recommend the clinical preventive action.

B. There is fair evidence to recommend the clinical preventive action.

C. The existing evidence is conflicting and does not allow to make a recommendation for or against use of the clinical preventive action; however, other factors may influence decision-making.

D. There is fair evidence to recommend against the clinical preventive action.

E. There is good evidence to recommend against the clinical preventive action.

L. There is insufficient evidence (in quantity or quality) to make a recommendation; however, other factors may influence decision-making.

† Adapted from the Classification of Recommendations criteria described in the Canadian Task Force on Preventive Health Care.

Clinical Algorithm(s)

None provided

Scope

Disease/Condition(s)

Health and well-being of First Nations, Inuit, and Métis women in Canada, with focus on:

- Sexual and reproductive health
- Maternal health
- Mature women's health

Guideline Category

Counseling

Evaluation

Management

Prevention

Risk Assessment

Screening

Treatment

Clinical Specialty

Family Practice

Internal Medicine

Obstetrics and Gynecology

Intended Users

Advanced Practice Nurses

Allied Health Personnel

Nurses

Physician Assistants

Physicians

Guideline Objective(s)

To provide health care professionals in Canada with the knowledge and tools to provide culturally safe care to First Nations, Inuit, and Métis women and through them, to their families, in order to improve the health of First Nations, Inuit, and Métis

Target Population

First Nations, Inuit, and Métis women in Canada and their families

Interventions and Practices Considered

1. Health care provider education regarding definitions and demographics of First Nations, Inuit and Métis peoples
2. Awareness of the social determinants of health among First Nations, Inuit, and Métis peoples
3. Understanding of health systems, policies, and services for First Nations, Inuit, and Métis peoples
4. Culturally appropriate management of First Nations, Inuit and Métis women's sexual and reproductive health

5. Gynaecologic and obstetric examination
6. Human immunodeficiency virus (HIV) counselling and screening to women who are pregnant or of childbearing age
7. Culturally safe approaches to HIV and other hematogenously transferred disease counselling, testing, diagnosis, and treatment
8. Culturally safe screening options for cervical cancer
9. Access to services for reproductive health needs, including terminations, without prejudice
10. Maternal health management
    - Management of substance dependence
    - Support and promotion of birth to rural and remote communities for women at low risk of complications
11. Management of mature women's health issues, including menopause
12. Culturally competent care
    - Use of patient's own language when possible
    - Healthcare facility provision of interpreters and First Nations, Inuit, and Métis health advocates on staff

Major Outcomes Considered

Access to and utilization of health care services and the Non-Insured Health Benefits Program

Methodology

Methods Used to Collect/Select the Evidence

Searches of Electronic Databases

Searches of Unpublished Data

Description of Methods Used to Collect/Select the Evidence

Published literature was retrieved through searches of PubMed, CINAHL, Sociological Abstracts, and The Cochrane Library in 2011 using appropriate controlled vocabulary (e.g., cultural competency, health services, indigenous, transcultural nursing) and key words (e.g., indigenous health services, transcultural health care, cultural safety). Targeted searches on subtopics (e.g., ceremonial rites and sexual coming of age) were also performed. The PubMed search was restricted to the years 2005 and later because of the large number of records retrieved on this topic. Searches were updated on a regular basis and incorporated in the guideline to May 2012. Grey (unpublished) literature was identified through searching the websites of selected related agencies (e.g., Campbell Collaboration, Social Care Online, Institute for Healthcare Improvement).

Number of Source Documents

Not stated

Methods Used to Assess the Quality and Strength of the Evidence

Weighting According to a Rating Scheme (Scheme Given)

Rating Scheme for the Strength of the Evidence

Quality of Evidence Assessment*

I: Evidence obtained from at least one properly randomized controlled trial

II-1: Evidence from well-designed controlled trials without randomization

II-2: Evidence from well-designed cohort (prospective or retrospective) or case-control studies, preferably from more than one centre or research

group

II-3: Evidence from comparisons between times or places with or without the intervention. Dramatic results in uncontrolled experiments (such as the results of treatment with penicillin in the 1940s) could also be included in this category

III: Opinions of respected authorities, based on clinical experience, descriptive studies, or reports of expert committees

* Adapted from the Evaluation of Evidence criteria described in the Canadian Task Force on Preventive Health Care.

Methods Used to Analyze the Evidence

Review of Published Meta-Analyses

Systematic Review

Description of the Methods Used to Analyze the Evidence

Not stated

Methods Used to Formulate the Recommendations

Expert Consensus

Description of Methods Used to Formulate the Recommendations

The quality of evidence was evaluated and recommendations were made according to guidelines developed by the Canadian Task Force on Preventive Health Care.

Rating Scheme for the Strength of the Recommendations

Classification of Recommendations†

A. There is good evidence to recommend the clinical preventive action.

B. There is fair evidence to recommend the clinical preventive action.

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D. There is fair evidence to recommend against the clinical preventive action.

E. There is good evidence to recommend against the clinical preventive action.

L. There is insufficient evidence (in quantity or quality) to make a recommendation; however, other factors may influence decision-making.

† Adapted from the Classification of Recommendations criteria described in the Canadian Task Force on Preventive Health Care.

Cost Analysis

A formal cost analysis was not performed and published cost analyses were not reviewed.

Method of Guideline Validation

Internal Peer Review

Description of Method of Guideline Validation

The consensus guideline document has been prepared by the Aboriginal Health Initiative Committee and approved by the Executive and Council of the Society of Obstetricians and Gynaecologists of Canada.

Evidence Supporting the Recommendations

Type of Evidence Supporting the Recommendations

The type of supporting evidence is identified and graded for each recommendation (see the "Major Recommendations" field).

Benefits/Harms of Implementing the Guideline Recommendations

Potential Benefits

Appropriate provision of culturally safe care to First Nations, Inuit, and Métis women and through them, to their families, in order to improve the health of First Nations, Inuit, and Métis

Potential Harms

Not stated

Qualifying Statements

Qualifying Statements

This document reflects emerging clinical and scientific advances on the date issued and is subject to change. The information should not be construed as dictating an exclusive course of treatment or procedure to be followed. Local institutions can dictate amendments to these opinions. They should be well documented if modified at the local level.

Implementation of the Guideline

Description of Implementation Strategy

An implementation strategy was not provided.

Implementation Tools

Foreign Language Translations

Resources

For information about availability, see the *Availability of Companion Documents* and *Patient Resources* fields below.

Institute of Medicine (IOM) National Healthcare Quality Report

Categories

IOM Care Need

Staying Healthy

IOM Domain

Effectiveness

Patient-centeredness

Identifying Information and Availability

Bibliographic Source(s)

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Adaptation

Not applicable: The guideline was not adapted from another source.

Date Released

2013 Jun

Guideline Developer(s)

Society of Obstetricians and Gynaecologists of Canada - Medical Specialty Society

Source(s) of Funding

This consensus guideline was supported by the First Nations and Inuit Health Branch, Health Canada.

Guideline Committee

Aboriginal Health Initiative Committee

Composition of Group That Authored the Guideline

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Financial Disclosures/Conflicts of Interest

Disclosure statements have been received from all contributors.

Guideline Endorser(s)

Aboriginal Nurses Association of Canada - Professional Association

Canadian Association of Midwives - Professional Association

Canadian Association of Perinatal and Women's Health Nurses (CAPWHN) - Professional Association

Indigenous Physicians Association of Canada - Professional Association

Inuit Tapiriit Kanatami - International Agency

MÃ©tis National Council - State/Local Government Agency [Non-U.S.]

Minwaashin Lodge - Nonprofit Organization

National Aboriginal Council of Midwives - Professional Association

National Aboriginal Health Organization - Nonprofit Organization

Native Youth Sexual Health Network - Nonprofit Organization

Pauktuutit Inuit Women of Canada - Nonprofit Organization

Royal College of Physicians and Surgeons of Canada - Medical Specialty Society

Society of Rural Physicians of Canada - Professional Association

Guideline Status

This is the current release of the guideline.

Guideline Availability

Electronic copies: Available from the Society of Obstetricians and Gynaecologists of Canada (SOGC) Web site . Also available in French from the SOGC Web site .

Print copies: Available from the Society of Obstetricians and Gynaecologists of Canada, La société des obstétriciens et gynécologues du Canada (SOGC) 780 promenade Echo Drive Ottawa, ON K1S 5R7 (Canada); Phone: 1-800-561-2416.

Availability of Companion Documents

A guide to avoiding re-traumatization of sexual abuse/assault victims during the birthing process is available in appendix 3 of the original guideline document .

Patient Resources

None available

NGC Status

This NGC summary was completed by ECRI Institute on September 27, 2013. The information was verified by the guideline developer on October 30, 2013.

Copyright Statement

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